EXHIBIT A.521

(11 of 17)

This chapter describes a number of ways to strengthen the Palestinian health system, to help achieve specific health targets and financial sustainability. Our principal recommendations are as follows:

- Integrate health system planning and policy development more closely, with meaningful input from all relevant governmental and nongovernmental stakeholders.
- Develop viable and sustainable health insurance and health care financing systems.
- Update, standardize, and enforce licensing standards for all types of health care professionals.
- Update, standardize, and enforce standards for licensing and accrediting health care facilities and services.
- Improve training of health professionals, including academic and vocational training programs that are internationally accredited, and implement comprehensive and ongoing programs for continuing medical education.
- Implement a national strategy on health care quality improvement. Systematically evaluate quality improvement projects; disseminate those that succeed.
- Develop and enforce national standards for the licensing, supply, and distribution of pharmaceuticals and medical devices.
- Improve health information systems for tracking data such as health and nutritional status, use and costs of inpatient and outpatient care, health care quality, health system staffing, pharmaceutical inventories, health insurance enrollment, and medical records.
- Improve research and evaluation capacity, including public health, clinical, and biomedical research.
- Improve public and primary health care programs, including an updated immunization program, comprehensive micronutrient fortification and supplementation, prevention and treatment of chronic and noninfectious disease, and treatment of developmental and psychosocial conditions.

While all of these recommendations are important, we suggest that immediate priority be given to the first (improving system-wide coordination and implementation) and the last (improving public and primary health care programs).

In practice, the appropriate strategies for addressing these issues will depend on many factors that are currently unknown, including the borders of a future Palestinian state, its security arrangements and relations with its neighbors, its governance structure, and economic conditions. We therefore discuss policy alternatives applicable to several possible scenarios.

We believe that local stakeholders can and should determine both the overall development process and the details of the health system, particularly given the expertise that already exists in Palestine and among Palestinians living abroad. At the same

time, we recognize that successful health system development in Palestine will require considerable outside resources, including technical and financial assistance. We estimate that the Palestinian health system would require between $125 million and $160 million per year in external support over the first decade of an independent state. For comparison, external support for the Palestinian health system averaged around $40 million per year over the period 1994–2000.

Successful development of the Palestinian health system is worthwhile in its own right, and it may be a relatively cost-effective way to help demonstrate the tangible benefits of independence and peaceful relations with neighboring countries. Moreover, health system development is an area where Israel, other neighboring countries, and the larger international community could play a constructive role, especially in areas such as health system planning, licensing and accreditation, development of information systems, and research.

Introduction

Envisioning a successful Palestinian health system is a broad and challenging mandate. Therefore, we started by defining a scope of work that would be both feasible and useful—one that could provide constructive new information to Palestinian stakeholders and other interested parties. We decided to focus primarily on key "macro-level" programs and institutions that we consider to be prerequisites for developing, operating, and sustaining a successful national health system in Palestine. These include policies and programs covering health system planning and coordination across regions and stakeholders; licensing and accreditation of health professionals, facilities, and educational programs; human resource development; health insurance and health care financing programs; pharmaceutical policy; research and evaluation programs; health information systems; disease prevention and health promotion; and public health. We believe that responsibility for the "micro-level" details of health system organization, infrastructure, and operation properly rests with the local stakeholders, including the Palestinian Ministry of Health, the United Nations Relief and Works Agency for Palestinian Refugees in the Near East, relevant private and nongovernmental organizations, and, ultimately, Palestinian consumers who use health care services.

To date, Palestinian stakeholders have produced two detailed national health plans, the first in 1994, published by the Palestinian Council of Health (1994), the second in 1999, published by the Ministry of Health (PA MOH, 1999). These two plans had similar structures, approaches, and goals. (Indeed, many of the goals of the first were repeated in the second because they had not been fully achieved.) The 1999 plan covered the period 1999–2003 and is currently being updated. These national health plans were complemented by the *National Plan for Human Resource Development and Education in Health,* completed in 2001 by the Ministry of Health, the Ministry of Higher

Education (now the Ministry of Education and Higher Education), and the Welfare Association (Welfare Association, PA, and Ministry of Higher Education, 2001a–f).[1] In part, these plans address system-wide development issues for Palestine, and we drew on this information extensively for our analyses. The national health plans also provide micro-level targets in many areas; e.g., the number, type, and geographic distribution of primary care clinics and different types of health care providers. Sample objectives from the 1999 national strategic health plan and the 2001 national plan for human resource development are included in Appendix 7.A of this chapter.

Although we regard the micro-level targets as generally appropriate, it is beyond the scope of this project to affirm their validity. Similarly, we did not perform detailed assessments of prevailing standards of care or quality of care, conduct salary surveys for health care workers in the government sector, assess the suitability of various pilot systems or programs as national models, or conduct similar analyses of particular health system details.

The health system of a future Palestinian state starts with many strengths. These include a relatively healthy population, compared with other countries in the region with similar levels of economic development; many highly qualified, experienced, and motivated health professionals, including clinicians, planners, administrators, technicians, researchers, and public health workers; and a strong base of local institutions. At the same time, there are a number of opportunities to strengthen the Palestinian health system to achieve specific health targets and financial sustainability over time.

Successful development of the Palestinian health system is worthwhile in its own right. It may also be a relatively cost-effective way to help demonstrate tangible benefits of peace. Historically, the health sector has benefited from considerable and ongoing cooperation between Palestinian and Israeli institutions and individuals, in areas such as policy formation and human resource development. Despite the current tensions in the region, we found high levels of support on both sides for continuing and strengthening such cooperation as circumstances permit. If done with appropriate sensitivity to local needs and preferences, and with respect for the extensive infrastructure of Palestinian institutions that is already in place, health system development could also be an area where outside parties—including the United States—could play a constructive role. On the other hand, the social and political costs of neglecting health system development may be significant, particularly given Palestinians' high expectations regarding health and health care.[2]

In the following sections of this chapter, we discuss the goals of a successful Palestinian health system. We describe our methods for conducting the health system analysis and provide brief background information on health and health care in the

---

[1] One of the authors of this chapter, Adel Afifi, was overall project coordinator for the development of the *National Plan for Human Resource Development and Education in Health.*

[2] One factor affecting these expectations is Palestinians' proximity to and experience with the Israeli health system.

West Bank and Gaza. The remainder of the chapter presents specific recommendations for strengthening (and, in some cases, establishing) institutions and programs to promote the current and future success of the Palestinian health system. We conclude with a discussion of costs—the investment that will most likely be required to sustain a successful Palestinian health care system in the first decade of independence.

For ease of exposition, we refer to the West Bank and Gaza as "Palestine." When we discuss Jerusalem, we refer to it explicitly. We refer to the Ministry of Health of the Palestinian Authority as "the Ministry of Health," abbreviated as MOH. We use "the Palestinian government" to refer generically to the current and future governments of Palestine; when we mean the Palestinian Authority, abbreviated as PA, we refer to it explicitly. We abbreviate the United Nations Relief and Works Agency for Palestinian Refugees in the Near East as UNRWA.

In our discussion, we refer frequently to primary, secondary, and tertiary health care. Primary care refers to basic health care that is traditionally provided by physicians trained in family practice, internal medicine, or pediatrics, or by nonphysician providers such as nurses. Secondary care refers to care provided by specialty providers (e.g., urologists and cardiologists) who generally do not have first contact with patients; these providers usually see patients after referral from a primary or community health professional. Tertiary care refers to care provided by highly specialized providers (e.g., neurologists, cardiac surgeons, and intensive care units) in facilities equipped for special investigation and treatment.

All monetary figures are in nominal U.S. dollars (i.e., dollars that are not adjusted for inflation), unless otherwise noted.

What Is a Successful Health System?

A "successful" Palestinian health system should, at a minimum,

- maintain an effective and well-regulated public health system
- provide reasonable access to high-quality preventive and curative services for all Palestinians
- maintain high-quality programs for training health professionals
- achieve health outcomes at the population level that meet or exceed international guidelines, such as those recommended by the World Health Organization (WHO)
- be effective, efficient, and financially viable
- contribute to peace and encompass the possibility of cooperation with neighboring countries on issues of common interest.

There are many ways to achieve these broad goals, ranging from incremental reform to radical redesign. The two national health plans (1994 and 1999) and the

National Plan for Human Resource Development and Education in Health (2001) articulate a vision of how the health system should develop over time, based mainly on incremental rather than radical change. This vision emphasizes public and primary health care as the "cornerstone" of service delivery, with expanded emphasis on health promotion and disease prevention capabilities. The public and primary care systems would be complemented by high-quality secondary and tertiary care systems, but these systems would be developed very carefully, and in a coordinated fashion, to ensure both clinical efficacy and economic efficiency.

In our view, this general vision conforms to the economic realities facing Palestine and to the available evidence from other settings regarding cost-effective health system development. We therefore adopted a similar focus on incremental reforms. In particular, we assume that the government will continue to be responsible for public health; a major provider of health care services; and a major, if not the primary, sponsor of health insurance over at least the first decade of an independent state.[3]

Alternative Scenarios for an Independent State

Our mandate is to describe strategies for strengthening the Palestinian health system to support the success of a future independent Palestinian state. However, the essential characteristics of the future state are currently unknown. In practice, characteristics such as the state's borders, security arrangements, and relations with its neighbors will significantly affect health system development. For this analysis, we therefore consider several possible scenarios for the characteristics of a future state, and we discuss how our policy recommendations might change for each scenario.

Population Mobility

Over the last several years, travel by Palestinians within the West Bank, between the West Bank and Gaza, and to East Jerusalem has frequently been restricted, particularly since the start of the second intifada in September 2000 and with the construction of Israel's separation barrier. Lack of mobility—for people and supplies—has limited patient and provider access to health care facilities, limited the collection of epidemiological and other health-related data, and been associated with declines in nutritional status, among other effects. The geographic closures have been sufficiently long-lasting that all stakeholders in the health system have taken active steps to minimize the short-term consequences, for instance by building new local treatment facilities

[3] In interviews with Palestinian stakeholders conducted as part of this analysis, some people expressed support for a transfer of the government's current health care delivery systems and health insurance programs to nongovernmental organizations (NGOs) or the private sector, which would leave the MOH responsible for planning, regulation, public health, provision for the indigent, and other functions for which the private sector is not well suited. Our recommendations do not foreclose such options. However, we think that these decisions must be made locally.

to help meet the acute needs of patients who would have traveled for care under less restrictive conditions.[4]

For purposes of the future health system, the relevant issue is the degree of population mobility that will be possible within a future Palestinian state. We consider two possible scenarios:

- *Unrestricted Domestic Mobility.* This scenario assumes free movement within the West Bank and within Gaza in a future independent Palestinian state. In general, it also assumes that patients would be able to travel between the West Bank and Gaza. Because these areas are relatively distant from each other, primary and secondary care would probably be handled within each area; travel to another area would become important if the patient is referred to a tertiary care center. Similarly, although the status of East Jerusalem is uncertain, we assume that Palestinians will have relatively open access to health care facilities in East Jerusalem.
- *Restricted Domestic Mobility.* This scenario assumes that movement within and between the territories of a future Palestinian state will be restricted (or, in the extreme case, prevented). Various factors could limit mobility, including the degree of territorial contiguity and Palestinian and Israeli security policies. Except as noted, health system development strategies do not depend on the specific cause of mobility restrictions, only on their scope and duration.

In practice, we regard free movement of patients, health professionals, and supplies within Palestine as prerequisites for successful health system development and operation. Restricted mobility would perpetuate and magnify the problems of staffing, supply, and patient access that have prevailed in the Palestinian health system during the second intifada. Moreover, strategies to mitigate these problems would be clinically and economically inefficient, relative to development under free mobility, particularly because the problems inhibit the development and operation of regional referral centers.

As a result, we consider unrestricted domestic mobility to be the default scenario for our analyses. However, at the end of each substantive subsection, we discuss how our recommendations would change under conditions of restricted mobility.

International Access[5]

The extent to which travel is restricted between an independent Palestinian state and other countries, particularly Israel and Jordan, may also significantly affect the future health system. We consider two possible scenarios:

---

[4] There has also been some damage to relevant infrastructure, particularly in conjunction with Israeli military operations in the West Bank during and after March 2002.

[5] Here, "access" refers to the right to travel to and stay in foreign countries, rather than insurance coverage or other factors that affect whether foreign institutions will accept Palestinian patients. As with domestic mobility, international access is likely to be contingent on successful security arrangements.

- *Unrestricted Access.* This scenario assumes that Palestinians face no categorical restrictions on travel to Israel, Jordan, or elsewhere for purposes of receiving health care or for professional training.
- *Restricted Access.* This scenario assumes that access for Palestinians to Israel, Jordan, and elsewhere for purposes of receiving health care or professional training is significantly restricted.

Unrestricted access is clearly preferable for health system development, because it provides additional options for meeting clinical and educational needs. As a result, we consider unrestricted access to be the default scenario for our analyses. However, at the end of each substantive subsection, we discuss how our recommendations would change under conditions of restricted international access.

Other Crosscutting Issues

Other characteristics of a future independent state will also affect health system development in important ways. For instance, any successful health system development depends on effective governance. This extends to all branches of government—i.e., the executive, legislative, and judicial branches. Effective development will also require meaningful inclusion of nongovernmental stakeholders in health system planning, policymaking, and policy implementation. Detailed consideration of Palestinian governance is provided in Chapter Two.

Successful security arrangements between Israel and Palestine are crucial to the successful development of Palestinian institutions. Continued conflict between the two states would, among other consequences, reduce the willingness of international donors to commit staff, money, and other resources to support health system projects; reduce the supply of private capital available for health system development from both local and international sources; encourage emigration of skilled and educated health professionals; and constrain public and private budgets.

Any successful health system development is also contingent on the financial resources available. As we discuss in detail below, a Palestinian health system that can truly be viewed as "successful" along the lines envisioned by our mandate will require considerable outside investment over at least the first decade of independence. The amount of outside resources and the period of time for which they are required depend on the performance of the Palestinian economy. Improved economic conditions will increase the level of both public and private resources available locally. Improved economic and social conditions are also associated with improved population health outcomes, independent of health care use. A detailed consideration of Palestinian economic development is provided in Chapter Five.

For ease of exposition, we do not define specific scenarios for these additional characteristics. However, we considered them in all our analyses and discuss their effects on our recommendations, as appropriate.

Methods

This chapter presents independent analyses conducted by the authors. Information about the Palestinian health system came from published and unpublished analyses by government organizations (e.g., the Palestinian and Israeli Ministries of Health), reports by international organizations (e.g., World Bank, various United Nations agencies, and the WHO), reports by Palestinian and international nongovernmental organizations (NGOs), papers in scientific journals, conference proceedings, working papers, and other formats. We did not collect new quantitative data.

We interviewed many Palestinian, Israeli, and international stakeholders who were experienced with and knowledgeable about, and in many cases have or had responsibility for, important aspects of the Palestinian health system. Interviews were primarily conducted in person during a trip to Palestine and Israel in May 2003. We asked all interview participants to allow themselves to be identified in this book. However, to help ensure that people felt free to express their views fully, interview participants were assured that no comments would be quoted directly or attributed to them in an identifiable way.

Study methods are described in further detail in Appendix 7.B of this chapter, which also includes an alphabetical list of interview participants. The letter of introduction we sent to local stakeholders is included in Appendix 7.C.

As we began this project, we learned that the European Union was sponsoring a comprehensive health sector review on behalf of the Palestinian MOH. That review aims to analyze major areas of the health sector, to assess the constraints resulting from the intifada, and to suggest the elements for a refocused midterm health development strategy. Additional information about that review is included in Appendix 7.D.

Background

This section provides a brief overview of health and health care in Palestine. The information was drawn from a variety of sources, particularly Barnea and Husseini (2002); the annual reports of the Ministry of Health (e.g., PA MOH, 2002a); the first and second Palestinian national health plans (see PA MOH, 1999; Welfare Association, PA, and Ministry of Higher Education, 2001a–f); Giacaman, Abdul-Rahim, and Wick (2003); the scientific literature; and data compiled at the Health Inforum web site (http://www.healthinforum.net/).[6] These and other references are provided in the bibliography.

We note that systematic collection of health data has been difficult since the start of the second intifada; we therefore report the most current information available to us at the time of this writing.

---

[6] Health Inforum describes itself as the "information body linked directly with the Core Group of the Health Sector Working Group." It was formed in 2001 through the collaboration of the World Health Organization, the Italian Cooperation, USAID, Maram, UNSCO, and UNDP.

Health Status

Life expectancy at birth in Palestine is about 70 years (as of 2000), higher than all neighboring countries except Israel. The infant mortality rate is approximately 23 per 1,000 live births, less than half the rate during the 1970s and comparable to or lower than rates in neighboring countries other than Israel (the Israeli rate is 6 per 1,000 live births). The maternal mortality rate was 19 per 100,000 births in 1998–1999, also down by more than half since 1980. The Palestinian maternal mortality rate is considerably better than those in Jordan, Iran, and Egypt, but some four times the Israeli and Kuwaiti rates (see Table 7.1).

Palestinian health indicators have improved significantly over time. Since the 1970s, standards of living and hygiene improved steadily, as did access to health care. For instance, the fraction of households with three or more people per room declined from 47 percent in 1975 to 28 percent in 1992 in the West Bank, and from 47 percent to 38 percent in Gaza. Similarly, by the mid-1990s, more than 90 percent of homes had electricity (up from around 25 percent in 1972–1975), and more than three-quarters of Palestinian households had access to clean, chlorinated drinking water (up from under one-quarter in 1972–1975). Access to primary health care services also improved significantly since 1970, as both the Israeli administration (before 1994) and the PA (from 1994 onward) expanded the number and geographic distribution of primary care and maternal and child health clinics.

Another factor contributing to lower infant mortality rates is the substantial expansion over time in the fraction of births occurring in a health facility or attended by a trained health professional: In 2001, 82 percent of Palestinian births occurred in a hospital, and 95 percent were attended by a health professional. The long-standing

Table 7.1
Basic Health Indicators, Palestine and Elsewhere (1998–1999)

	Life Expectancy at Birth (years)	Infant Mortality Rate (per 1,000 live births)	Mortality Rate for Children Under Age 5 (per 1,000 live births)	Maternal Mortality Rate (per 100,000 live births)
Palestine	70	23	28	19
Israel	78	6	6	5
Jordan	68	30	36	41
Egypt	67	51	69	170
Kuwait	68	12	13	5
Qatar	72	15	18	10
Iran	69	29	33	37
Yemen	58	87	121	350
United States	77	7	8	8
France	78	5	5	10

SOURCES: United Nations Children's Fund, 2000; PA MOH, 2002a.

strength of the Palestinian immunization program also played an important role in improving child health. Immunization rates among children for the major vaccine-preventable diseases (e.g., polio, measles, mumps, rubella, diphtheria, tetanus, pertussis, and most recently hepatitis B) have exceeded 95 percent since the mid-1980s; as a result, incidence of these diseases has been low or zero since the 1980s. Also, from 1986 to 1998, infants and pregnant women attending government maternal and child health centers and village health rooms received vitamin and mineral supplements (iron and vitamins A and D for infants, and iron and folate for women). These supplements helped improve infant growth patterns and reduce malnutrition and susceptibility to infectious disease.

Some indicators, such as immunization coverage and the fraction of births occurring in medical facilities, have declined since the beginning of the second intifada, primarily because of travel restrictions for providers and patients. However, the magnitude of these changes is currently unknown.

Incidence of gastroenteric and parasitic diseases has also declined significantly since the 1980s, and outcomes have improved. However, these conditions remain important health problems, primarily because of hygienic conditions (which have deteriorated since the start of the second intifada). Other areas of concern include hepatitis A, which is endemic in Palestine; respiratory infections; and meningitis. To date, vaccines for hepatitis A, haemophilus influenza B, and varicella have not been added to the Palestinian immunization program.

Acute and chronic malnutrition are also relatively prevalent, as are anemia and other micronutrient deficiencies. Nutritional status has declined in the last few years, as measured by indicators such as anthropometric status of children, anemia levels, and reported nutrient intake. Factors that might contribute to declining nutritional status include declining economic conditions, particularly since the outbreak of the second intifada, and the cessation in 1998–1999 of routine vitamin and mineral supplementation for infants and pregnant women in the government health system.[7]

As the role of infectious disease has declined in Palestine, the relative importance of noncommunicable and chronic illness has risen. As in most countries, stroke, ischemic heart disease, hypertension, diabetes, and cancer together account for more than half of adult mortality, and incidence and prevalence rates for these conditions have been rising over time. Among infants and children, one-third of deaths are due to accidents (of all kinds), more than any other identifiable category of causes.

Health status in Palestine is described in detail elsewhere, particularly in annual reports published by the MOH. However, data regarding inequities in health status between rural and urban residence, between refugee and nonrefugee populations, and

[7] Declines in nutritional status have been documented in several recent studies, which differ primarily in their estimates of the magnitude of the decline. Another recent survey, conducted by the WHO, found that other health status indicators had not declined significantly during the second intifada but cautioned that such declines might be forthcoming if social and economic conditions continued to decline.

by geographic region are relatively limited. Our recommendations for improving data collection are discussed below under "Strengthening Key Institutions, Policies, and Programs."

Health System Organization

Before 1994. Prior to being occupied by Israel in 1967, Gaza was administered by Egypt, while the West Bank and East Jerusalem were administered by Jordan. Health institutions in each area operated independently from each other. Gaza followed Egyptian protocols for medical licensing and other relevant issues, while the West Bank followed Jordanian protocols.

Between 1967 and 1994, these areas were both administered by the Israeli Defense Ministry. Gaza and the West Bank had separate chief medical officers and administrative structures, and they continued to follow different protocols in certain health policy areas, particularly those relating to medical licensing and supervision of health facilities. While many aspects of health policy were standardized for both the West Bank and Gaza, there were also some differences between the two areas, including differences in vaccination programs, maternal and child health programs, primary care services, and health insurance. As we discuss further below, the policy differences between Gaza and the West Bank remain relevant today.

Since 1948, UNRWA has been charged with providing basic health services to registered Palestinian refugees, including in the West Bank and Gaza. Refugees eligible for UNRWA services include those Palestinians (and their descendants) who were displaced from their homes because of the war between Israeli and Arab armies in 1948. Currently, approximately 75 percent of Gaza residents and 30 percent of West Bank residents—a total of some 1.5 million people in those areas—are designated as refugees. During most of the period of Israeli administration, UNRWA headquarters were in Vienna, Austria, and most planning for UNRWA health programs in Palestine was done there. UNRWA headquarters were subsequently moved to Amman, Jordan.

As described by some of its top Israeli managers, the objectives of the Israeli administration were to provide good health care, given the available resources; to minimize the risk of political unrest; and to provide a stable basis from which to negotiate a political solution.[8] The top managers of the government health system were Israeli physicians appointed by the Israeli Defense Ministry, with supervision from the Israeli Health Ministry. High-level planning was directed by the Israeli administration, generally via joint committees with senior Palestinian health officials. Most staff of the government health sector were Palestinian, including administrative and clinical personnel. Some independent review was provided by visiting experts from the WHO, the International Committee of the Red Cross, and other organizations.

---

[8] These objectives are described by Yitzhak Sever and Yitzhak Peterburg in Barnea and Husseini (2002). Both served as chief medical officers with the Israeli Civil Administration, in the West Bank and Gaza, respectively.

Israel aimed at financial self-sufficiency of the government health sector. Approximately half of the total health budget came from Palestinian taxes (and health insurance premiums) during the 1970s, rising to 75–100 percent during the 1980s and early 1990s. Consistent with these financial goals, the government health system placed a heavy emphasis on public health and primary care, particularly immunization programs for vaccine-preventable illness, and maternal and child health programs. Between 1970 and 1993, the number of government maternal and child health clinics increased by 488 percent, while the number of general government clinics increased by 63 percent.

In contrast, relatively little capital investment was directed toward secondary and tertiary care. For instance, the number of government hospital beds in the West Bank and Gaza increased by just 13 percent between 1970 and 1993. Similarly, in 1992, approximately 10 percent ($5.9 million) of the government health budget for Palestine went to development; the rest went toward operating expenses.[9] Hospital development efforts were focused on strengthening personnel and capacity in key departments, particularly anesthesia and internal medicine; also, all regional hospitals developed fully operational renal dialysis units during this period, and several hospitals were developing tertiary care services such as cardiac and neurosurgery.

Transfer to the Palestinian Authority. Following the Oslo Accords in 1993, Israel and the Palestinians negotiated the transfer of responsibility for health services and health policy from Israeli administration to the newly formed PA. The PA assumed health sector responsibility for Gaza and Jericho in May 1994 and for the rest of the West Bank at the end of that year.

The Palestinian health system is commonly described as consisting of four "sectors": the government sector, led by the MOH; the private sector; the NGO sector; and the sector run by UNRWA. The MOH serves as the principal administrative and regulatory body for the Palestinian health system, although responsibility for some relevant areas is also held by other ministries, including the Ministry of Finance (e.g., for budgeting), the Ministry of Planning (e.g., for infrastructure development programs), and the Ministry of Education and Higher Education (for academic and vocational training programs). The MOH manages public health services and delivery of primary, secondary, and tertiary care in government facilities. The MOH organizational chart from the second Palestinian national health plan (published in 1999) is reproduced as Figure 7.1.

Health Care Infrastructure

Table 7.2 provides data on some key indicators of health system infrastructure and capacity in Palestine, along with some international comparisons. The role of the government

[9] The Israeli administration published data on government health sector expenditures for the West Bank from 1990 ($26.7 million, $34 per capita) through 1993 ($37.2 million, $37 per capita). Relatively little public data were available for other periods, or for Gaza. Moreover, budget records were not among the information provided to the MOH by Israel when responsibility for the health system was transferred to the PA.

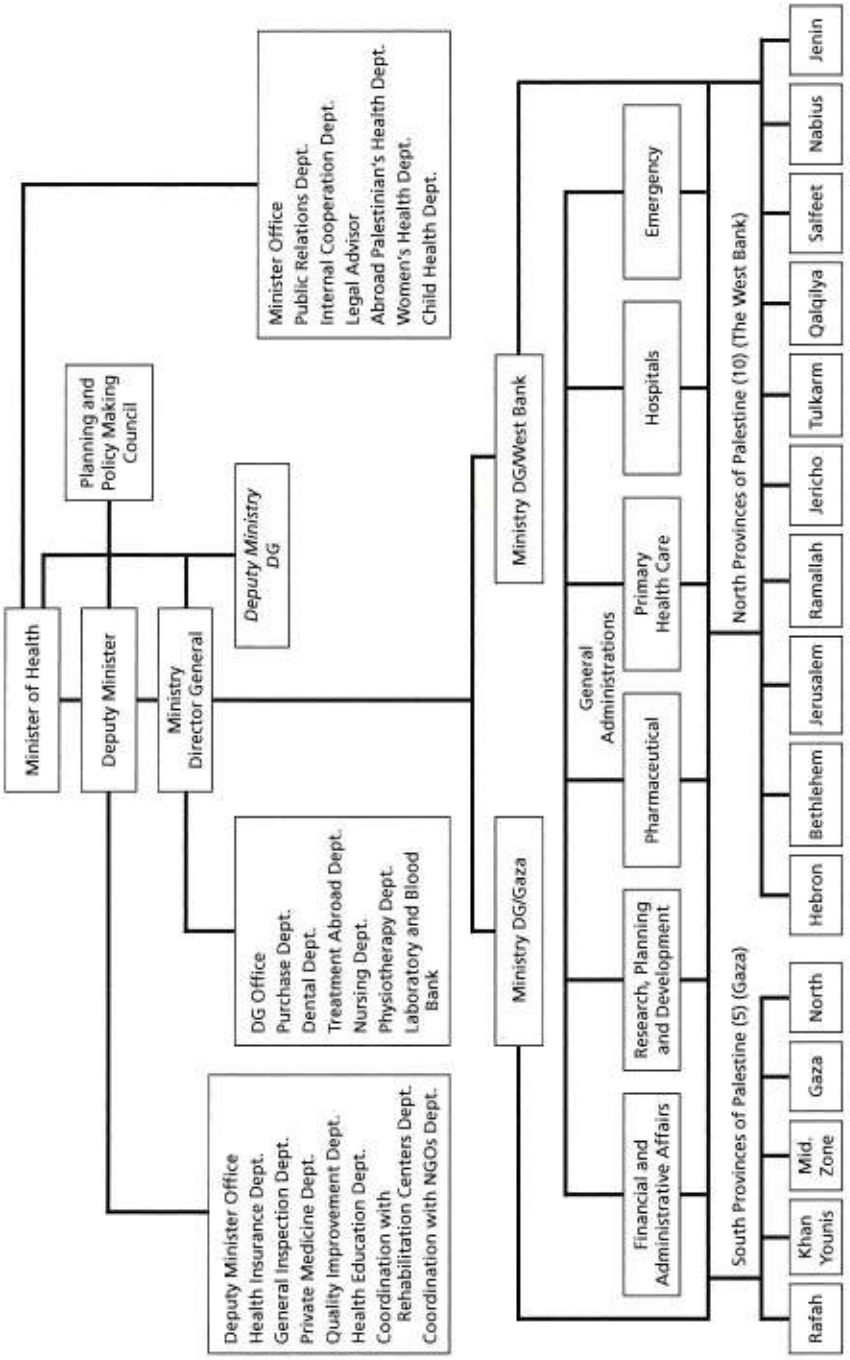

Figure 7.1
Ministry of Health Organizational Structure

SOURCE: PA MOH, 1999, p.43.
NOTE: Our understanding is that this organizational chart remains generally accurate, although some details may have changed since it was produced.

RAND MG146-7.1

Table 7.2
Health System Infrastructure, Palestine and Elsewhere (2000–2001, unless otherwise noted)

	Palestine	Israel	Jordan	Egypt	European Union	United States
GNP per capita	$1,771	$16,710	$1,650[c]	$1,080[c]	$22,363	$35,182
Health system spending per capita	$111[a]	$1,671	$139	$45[f]	$2,123	$4,887
Health system spending as a percentage of GNP	6%	10%	8%	4%[g]	10%	14%
Hospital beds per 100,000 population	137	614	160[d]	210[d]	622	360
Hospital occupancy rate	76.9%[b]	93%[b]	70%[g]	55%[e]	78%[b]	67%
Physicians per 100,000 population	84	377	165[d]	76	349	240
Nurses per 100,000 population	120	590	250[c]	N.A.	668	810
Dentists per 100,000 population	9	114	49[c]	6	64	60
Pharmacists per 100,000 population	10	62	N.A.	6	79	62

SOURCES: World Bank, 1998, 2003b; World Health Organization, 2001, 2004; The Hashemite Kingdom of Jordan, 2004; Gaumer et al., 1998; Medistat, 2003; Partnerships for Health Reform, 1997; PA MOH, 2002a; European Commission and Eurostat, 2001; Barnea and Husseini, 2002; Organisation for Economic Co-operation and Development, 1997, 2004; Centers for Disease Control and Prevention, 2003.

NOTES: N.A. = not available. As described elsewhere in this chapter, gross national product (GNP) per capita has since fallen substantially as a result of the second intifada.

[a] Data are from 1997.
[b] Occupancy rate is for MOH hospitals in Palestine and for acute care hospitals elsewhere.
[c] Data are from 1996.
[d] Data are from 1998.
[e] Data are for all hospitals in 1996.
[f] Data are for 2002.
[g] Data are for government hospitals in 1996; occupancy in private hospitals for that year was 49 percent.

sector in health care delivery—relative to that of the NGOs, private, and UNRWA sectors—is presented in Table 7.3.

Health System Funding and Expenditures

The annual operating budget for the MOH peaked at around $100 million in 1997 but has declined fairly continuously since then because of declining revenue from health insurance premiums and a general budget crisis. At least up to 2000 and the second intifada, government revenue for the health sector came from general taxation (60 percent), health insurance premiums (25–30 percent), and patient cost sharing (10–15 percent). In 1998, government health spending was $88 million, of which

Table 7.3
Distribution of Capacity Across the Sectors of the Palestinian Health System (2001) (in percentage)

	Government	UNRWA	NGOs	Private
General hospital beds	53	1	37	10
Specialized hospital beds	75	N.A.	13	12
Maternity hospital beds	31	N.A.	33	37
Primary health clinics	61	8	30	N.A.
Health employees	56	7	30	7
Expenditures (1997)[a]	33	11	16[b]	40[c]

SOURCES: PA MOH, July 2002a; World Bank, 1998.

NOTE: N.A. = not available.

[a] Includes capital expenditures.

[b] Combines international donors and NGOs.

[c] Includes household expenditures and private capital investments.

$39 million was spent on salaries, $25 million on drugs and medical supplies, $9 million on treatment abroad, and $14 million on other operating costs.[10]

Overall, Palestinian health system spending was estimated to be around $320 million in 1998, including infrastructure development.[11, 12] In addition to the $88 million spent by the MOH, spending on health care in the private sector was approximately $90 million per year, while NGO spending on health care was estimated to be around $70 million.[13] UNRWA spending on health in Palestine was around $18 million in 1998.

The remainder of national health expenditures—some $54 million in 1998—came from other sources, particularly international donors.[14] Between mid-1994 and mid-2000, international donors disbursed approximately $227 million in health development assistance to Palestine, excluding humanitarian assistance. This averaged about

[10] The component for salaries has been the largest, and fastest growing, part of MOH spending, with the number of MOH employees more than doubling between 1993 and 2001, from 4,020 to 8,285. This was driven in part by a doubling of the number of government outpatient clinics and increases in hospital capacity during this period.

[11] We use 1998 as a reference point here because relatively detailed data were available to us for that year and because financing in subsequent years was significantly distorted by the second intifada. Additional information on health system spending is provided in the "Cost" subsection of this chapter.

[12] Palestine spent approximately 6 percent of gross national product (GNP) on health in 1998. The fraction of GNP spent on health in Israel was somewhat higher (10 percent). More important, Israeli GNP per capita—and thus health spending per capita—was more than nine times higher than that in Palestine (World Bank, 1998; PA MOH, 2002a). Moreover, Palestinian national income and health system spending have fallen considerably since 2000; this is discussed further in the "Cost" subsection of this chapter, and in Chapter Five.

[13] Publicly available data on private-sector and NGO spending on health are limited, so these estimates may be somewhat inaccurate.

[14] All of these figures exclude East Jerusalem. Estimates for the amount contributed annually by Palestinians in East Jerusalem to Israeli national insurance—which includes health insurance—range from $30 million to $40 million.

$38 million per year, more than six times the governmental development budget during the last years of Israeli administration. Although detailed data on the distribution of international donations between infrastructure development and ongoing expenses are unavailable, donors have certainly preferred to direct donations toward the former, and they have been particularly reluctant to fund the operating expenses of the government sector. For example, of the $224 million in donor commitments made to health sector development to cover the period 1994–1997, only 5 percent ($12 million) was specifically designated for recurring costs; 24 percent of the total commitments was specifically designated for other purposes, mostly equipment and construction, while the designated purpose for the rest was mixed or unspecified.[15]

A schematic for the flow of funds in the health system is reproduced as Figure 7.2.

Patient Benefits and Costs

Government Health Benefits. Under PA administration, the entire Palestinian population, regardless of health insurance or refugee status, is entitled by statute and government policy to immunizations, prenatal and postnatal care, preventive and curative care for children until age three, basic preventive services, hospital care, and community mental health services, without patient cost sharing. The predominant source of health insurance in Palestine is currently the government insurance program, which covers primary, secondary, and tertiary curative care. Palestinians who officially reside in East Jerusalem (i.e., those with a Jerusalem identity card) participate in the compulsory Israeli health insurance programs and receive care under those systems. Participation in the government plan is mandatory for government (i.e., PA and municipal) workers and for Palestinians working in Israel. Other people may join the government program voluntarily as individuals, households, or groups organized around a firm or workplace.

The current government health insurance program is modeled closely on the system originally introduced by Israel. However, the MOH deliberately reduced insurance premiums after 1994 to promote enrollment. This strategy was generally effective: enrollment increased from 20 percent of households in 1993 to 55 percent in 1996. Enrollment subsequently declined because of a budget crisis in the government health sector and worsening economic conditions. However, premiums were recently waived for large segments of the population, particularly the households of people who lost jobs in Israel since the onset of the second intifada or who have been hurt in clashes with Israel, and enrollment has consequently increased.

Until the outbreak of the second intifada, health insurance premiums for government employees and participants via workplace groups were 5 percent of a worker's base monthly salary, with a monthly minimum of $8.50 and a maximum of $16.[16]

---

[15] We lack similar data on the distribution of actual disbursements, as opposed to donor commitments.

[16] Premiums and cost sharing are paid in Israeli shekels (NIS). Costs in U.S. dollars are based on a rate of $1 = 4.74 NIS, the rate at the end of March 2003.

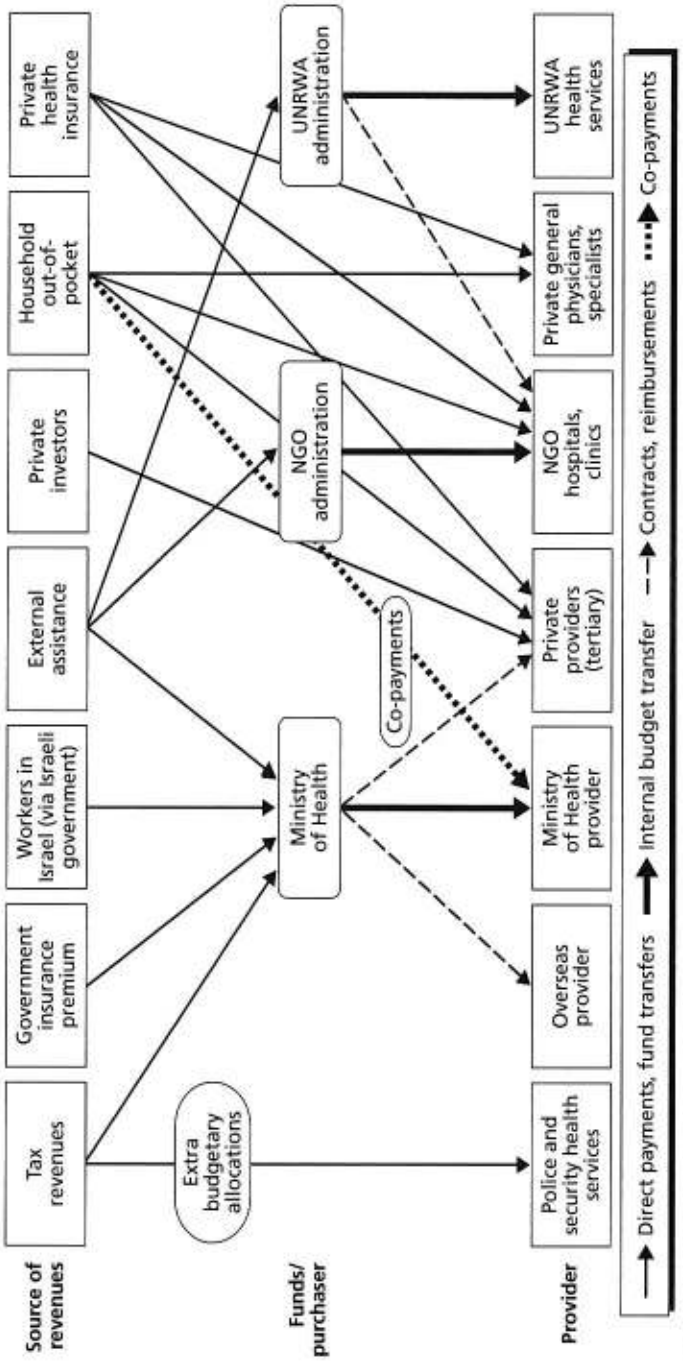

Figure 7.2
Flow of Funds in Palestinian Health System

SOURCES: World Bank, 1998, p. 24. Also appears in Barnea and Husseini, 2002, p. 184.

NOTES: Several sets of arrows are missing from this figure. For instance, arrows should run from the MOH to NGOs and the private sector. As described below, government health benefits do cover some care from such providers when patients are referred because a covered service is not available in the government system. Also, an arrow should run from UNRWA to the MOH. As also described below, UNRWA pays government insurance premiums for some UNRWA beneficiaries.

RAND MG146-7.2

Private participants were charged $10.50 per month for individual coverage and $16 for household coverage.[17] Palestinians working in Israel were charged $20 per month, a small part of which was deducted by Israel to pay for care provided there. Parents over age 60 could be covered for an additional $3 per month in premium payments. Health insurance premiums were waived for households that met "hardship" criteria, with the MOH assuming responsibility for them.[18]

When economic conditions declined significantly after the outbreak of the second intifada, enrollment in the government health system also fell. Correspondingly, the fraction of the MOH operating budget that came from health insurance premiums fell from 40 percent in 1999 to 24 percent in 2001. This revenue source was then substantially reduced when the PA decided to waive government health insurance premiums for large segments of the population, as a result of the emergency conditions associated with the second intifada.[19] As of this writing, insurance premiums remain waived.

Even for people whose premiums have been waived, some co-payments remain. Under the government health insurance program, patients are charged $0.21 per laboratory test and for imaging services. If a private provider refers patients to the government sector for care, patients are charged $4 per referral by the government insurance program, although apparently this charge is often not enforced. Pharmacy co-payments are described below. With the exception of these charges, there is no cost sharing for outpatient and inpatient care in the government sector under the government insurance plan, nor for care in the NGO or private sectors (or in foreign institutions) for patients who receive appropriate referrals from the government system. In theory, the government system pays for care in the NGO and private sectors only when an appropriate referral has been obtained. Referrals are supposed to be provided only when needed services are not available from government providers.

Under the pharmacy benefit of the government insurance program, patients are charged $0.63 per prescription for medications ($0.21 for children up to age three). Patients obtain prescription drugs from government clinics; in general, drugs obtained from private pharmacies are not covered by the government plan. The MOH developed a national essential drug list, which was released in 2002. In principle, all the drugs on the list—and only the drugs on the list—are available to patients in the gov-

---

[17] For comparison, Palestinian gross national income was around $1,800 per capita in 2000 and $1,070 per capita in 2002, based on data from the MOH.

[18] Hardship cases included indigent households and those that met certain other criteria, such as households headed by widows. In 1998, before the second intifada and the waiving of premiums for many people, approximately 20 percent of participants in the government health insurance system were hardship cases; 30 percent were required to participate as government employees; 20 percent were required to participate as workers in Israel; and 30 percent were enrolled on a voluntary basis, as individuals or via group contracts.

[19] Enrollment in the government insurance system increased again when premiums were waived, to some 80 percent of the population. However, the MOH budget has not been increased to fully reflect the associated liabilities for the government health system. We discuss health insurance in greater detail in "Strengthening Key Institutions, Policies, and Programs" below.

ernment health sector. In practice, not all covered drugs are consistently available in all geographic areas, because of factors including insecure supply, poor distribution, and the MOH planning process. However, purchase of drugs from private pharmacies is not covered by the government health plan, even if the drugs were prescribed by but were unavailable in the government health system. We discuss pharmaceutical policy in greater detail in "Strengthening Key Institutions, Policies, and Programs" below.

The MOH is the main provider of hospital beds, particularly in Gaza. The MOH is also the main provider of primary care, operating a large network of primary care clinics, maternal and child health centers, and village health rooms. Immunizations are provided by the MOH at its primary care sites and in UNRWA clinics, as well as via traveling immunization teams for areas that lack on-site services.

Health care providers in the government sector are salaried public employees. Providers in UNRWA and most NGOs are also salaried employees. Private practice has expanded since 1994 but is still fairly limited, especially in Gaza.

United Nations Relief and Works Agency. UNRWA's health services focus on disease prevention and control, primary care, family health, health education, physiotherapy, school health, psychosocial support services, and environmental health. There is no patient cost sharing for these services, which are provided mainly through a network of UNRWA outpatient clinics throughout the West Bank and Gaza, primarily in areas with significant concentrations of refugees. UNRWA also provides some secondary care; patients must pay 25 percent of the cost of care (10 percent in hardship cases) for these services, which are provided through one UNRWA hospital, in the West Bank, and in public and NGO hospitals with which UNRWA contracts for inpatient care. In general, UNRWA does not cover care for chronic and noncommunicable diseases. For some conditions, particularly cancer, UNRWA "sponsors" patients' care by covering the cost of enrolling the patient in the government health insurance program.

UNRWA's budget is determined by the United Nations General Assembly. However, in practice the budget allocation is not always fully funded by donor countries. For example, in 1998, donor countries provided $18 million (72 percent) out of an approved health budget of $25 million for Palestine.

Since this analysis is framed in terms of a future independent Palestinian state, it is worth commenting on the likely role of UNRWA in that context. Nearly all Palestinian stakeholders whom we interviewed thought that the role of UNRWA in Palestine would be eliminated with a final political settlement and the establishment of an independent state, and that the UNRWA system would probably be transferred to the MOH eventually.[20]

Use of UNRWA services does not affect eligibility for government health insurance and services.

NGOs and the Private Sector. Nongovernmental organizations have played a very important role in all levels of the Palestinian health system, during both the Israeli and

[20] Since UNRWA's services are financed by international donations, the MOH and donor countries would need to work together to ensure that such a transfer does not cause a financial shock to the Palestinian health system.

Palestinian administrations. Although some international NGOs operate in Palestine, the role of indigenous NGOs is at least as great. NGOs include organizations with social, political, and religious motivations. Historically and today, NGOs in Palestine have provided services including outpatient and inpatient care, psychosocial support, rehabilitation, health education, and emergency care. They have also been active in health promotion and health education, consumer activism, health planning, infrastructure development, human resource development, and other aspects of the health system.

NGO development was particularly significant during the first intifada and the period immediately preceding the Oslo agreement (1987–1993), when NGOs were one feasible outlet for developing national institutions. Following the transfer of the health system to the MOH, international donors shifted substantial resources from the NGO sector to the government sector, a trend that was somewhat reversed following the start of the second intifada.

Private investment in the health sector was relatively limited before 1994 but grew considerably between 1994 and 2000. The private health sector now includes clinics and hospitals; pharmacies; laboratories; radiology, physiotherapy, and rehabilitation centers; and medical equipment manufacturing facilities. In addition, there is a growing domestic pharmaceutical industry, which produces approximately 700 different products and supplies substantial amount—estimated to be around one-half—of the Palestinian demand for prescription drugs. There have been some attempts to establish private health insurance programs, but private coverage has never exceeded 2–3 percent of the population. Private insurance plans have essentially been eliminated by the economic hardships accompanying the second intifada. However, private expenditures on health remain considerable (see Table 7.3).[21]

Strengthening Key Institutions, Policies, and Programs

For each of ten key areas, we present background information and our recommendations. We also briefly describe the effects of alternative scenarios. Our major recommendations are summarized in Table 7.4.

Health System Planning, Policy Development, and Policy Implementation

Background. During the period of Israeli administration (1967–1994), planning for the government health sector was led primarily by Israelis, with some Palestinian participation in policy formation and with Palestinian administrative support. Examples of joint policy development include the 1985 Adler Committee on health planning for the West Bank and standing committees such as the Child Health Committee in Gaza. Planning for UNRWA was mainly conducted at UNRWA headquarters in Vienna for

[21] The Palestinian Central Bureau of Statistics (2000b) estimates that 3–4 percent of household income is spent on health care (including health insurance premiums) (Barnea and Husseini, 2002).

Table 7.4
Recommendations for Palestinian Health System Development

Area	Recommendation
Health system planning, policy development, and policy implementation	The Palestinian government should integrate health system planning and policy development more closely, with meaningful input from and coordination with all relevant governmental and nongovernmental stakeholders.
Health insurance and health care finance	The Palestinian government should develop viable and sustainable health insurance and health care financing systems.
Licensing and certification of health professionals	Palestinian standards for licensing and certifying all types of health professionals should be updated, standardized, and enforced.
Licensing and accreditation of health care facilities and services	Palestinian standards for licensing and accrediting health care facilities and services should be updated, standardized, and enforced.
Human resource development	Palestinian institutions should implement a human resource development strategy for the health professions to ensure an adequate supply of appropriately trained personnel for the Palestinian health system.
Health care quality improvement	A national strategy on health care quality improvement should be developed and implemented, with systematic evaluation of quality improvement projects and dissemination of those that succeed.
Policies on prescription drugs and medical devices	Policymakers should implement national strategies on the licensing, supply, and distribution of pharmaceuticals and medical devices to ensure a stable and adequate supply of safe and cost-effective products.
Health information systems	Palestinian policymakers should develop comprehensive, modern, and integrated health information systems.
Research	Palestinian policymakers should develop national strategies regarding public health, health services, clinical, and basic science research.
Programs for rapid improvement	The MOH should implement comprehensive programs to improve nutritional status, including food fortification, micronutrient supplementation for high-risk groups, and promotion of healthy dietary practices.
	The national immunization program should be updated, and the costs of purchasing and distributing vaccines should be explicitly covered by the government budget.
	The MOH and other stakeholders should expand the scope of available primary care services and expand access to comprehensive primary care.
	The MOH and other stakeholders should develop comprehensive strategies for addressing psychosocial needs, particularly those relating to the exposure of children to violence.

all five areas of UNRWA activity (Syria, Lebanon, Jordan, West Bank, and Gaza), with some local Palestinian input. Government and UNRWA activities were coordinated to some degree, but many policies varied between these two sectors. The Israeli administration exercised some control over the NGO sector's infrastructure and programs. However, in many respects, NGOs explicitly aimed to compete with the government

in the health sector for political reasons; coordination with the government was correspondingly low.

When Palestinian national health planning started in the years prior to the Oslo Accords, its leaders followed a process that was explicitly designed to be inclusive. The first national health plan called for the creation of a "health council" to oversee the health system, with the responsibility of developing strategic plans for future action, developing policy across both public and private health care programs, and monitoring and evaluating progress in meeting policy targets, among other functions. The plan called for this council, referred to as a "central authority," to involve all relevant stakeholders in its activities, including "the private sector, the nonprofit sector, the university system, businesses, organized labor, and the voluntary sector," as well as local communities, and to ensure that these stakeholders participate in a meaningful way (Palestinian Council of Health, 1994).

In 1992, the Palestine Liberation Organization authorized the establishment of the Palestinian Council of Health, which completed the first Palestinian national health plan and acted as the national planning body until the MOH was established. This council included representatives from numerous NGOs, as well as private providers, academics, UNRWA, and other relevant stakeholders, all of which were involved in the council's activities.[22] Many council participants expected that this organization would serve as the "central authority" referred to in the first national health plan, once it became clear that responsibility for the Palestinian health system would be transferred to the PA under the Oslo Accords in 1994. As the MOH became established, however, many of the council's responsibilities—along with much of its staff—shifted to the new MOH. Although the council was not disbanded, it quickly stopped functioning as the national planning and coordination body for the health system.

As we have noted, national health planning has continued under the MOH, and the planning process has involved representatives from NGOs, the private sector, UNRWA, and the donor community. However, there is no systematic national process for ensuring that health system development is tailored to the goals articulated in the national health plan or other relevant planning documents. The MOH has had limited success exercising its managerial authority over the health system, and neither the MOH nor any other national institution provides effective overall coordination. Instead, there is a general lack of coordination in policy development and implementation across parts of the PA, between the West Bank and Gaza, and across the four major sectors of the health system (government, NGO, private, and UNRWA). Organizations across the four health sectors compete in an effort to advance their own priorities, rather than pursuing system-wide or national priorities; there is no consistent national process for reviewing new infrastructure projects to ensure that health infrastructure is developed efficiently; there are no modern standards for many key aspects of health

[22] Participation by Palestinian staff of the (Israeli) government health system was initially limited, for political reasons.

system operation and minimal enforcement of the standards that do exist.[23] In addition, consumer input to the planning process has been limited.

In our view, the lack of coordination in policy development and implementation has limited progress toward achieving the health and health system targets specified in the national health plans, reduced the financial viability of the health care system, and undermined public confidence in the government health system and possibly in the government generally. These conditions apply in some degree to nearly all aspects of the health system, including the development and operation of public health programs and clinical infrastructure, health care finance, and the pharmaceutical sector. One possible exception is human resources and health education, where the MOH and the Ministry of Education and Higher Education have recently established a body with authority to accredit any new health-related academic or vocational training program.

Recommendation: The Palestinian Government Should Integrate Health System Planning and Policy Development More Closely, with Meaningful Input from and Coordination with All Relevant Governmental and Nongovernmental Stakeholders. There are many ways to improve health system planning and coordination. However, effective planning and coordination processes are likely to share the features described below.

The planning and coordination processes should be implemented by a governmental authority. Nongovernmental stakeholders can help inform planning and the policymaking process, but they cannot independently develop national policy. National health planning, policymaking, and coordination across stakeholders should be led by a governmental body, with its responsibilities defined by legislation and/or regulation. Relevant areas of responsibility include

- overall responsibility for promoting the health of Palestinians
- establishment of national health priorities and targets
- financing of public health
- assurance of access to health care at the primary, secondary, and tertiary levels
- epidemiology and health status monitoring
- environmental quality and food and water safety
- safety and efficacy of pharmaceuticals and medical products
- maternal and child health
- control of communicable diseases
- control of noncommunicable diseases, injuries, and conditions
- legislation, licensing, and regulation of health care facilities and personnel (including educational standards)

---

[23] In some ways, competition between NGOs and the government sector has intensified since 1994. Now, as under Israeli administration, some NGOs compete with the government sector, for ideological reasons and because of a scarcity of resources. Additionally, the MOH has competed with certain NGO activities, perhaps in an effort to establish authority over a health system in which several major NGOs were already well established when the MOH was created.

- promotion of quality and equity in health care
- collection of national health accounting data and other data necessary for health system planning, policy development, and policy implementation.

It might seem that the most obvious entity for leading the planning process, and for coordinating across stakeholders, is the MOH. The MOH has led many of the health system planning efforts since 1994; it has considerable relevant expertise among its staff; and, at least in principle, the MOH already has responsibility for system-wide planning and coordination and at least some of the authority to carry it out. On the other hand, the MOH has had limited success to date in developing, implementing, and enforcing policy for the health system as a whole. For example, the MOH Health Sector Working Group—which includes the MOH, the Ministry of Planning, several international donors, the WHO, and other stakeholders—advises the MOH regarding policy development. But its decisions are not binding on the participating organizations, let alone on nonparticipating stakeholders. In addition, the MOH operates independently in Gaza and in the West Bank in many respects, even before the second intifada.

There are presumably many reasons for this, which will need to be addressed if an integrated planning process is to succeed. For instance, the MOH may have lacked the resources or expertise to implement effective planning and coordination at a national level; it may have lacked the necessary statutory authority; and/or it may have lacked the political will or ability to exercise such authority. Most interview participants favored the last of these explanations. In practice, the PA as a whole and most of its departments, including the MOH, have suffered from a weak level of authority over the sectors for which they are responsible; inefficient management practices; and autocratic, inconsistent, and nonparticipatory decisionmaking processes. The issue of Palestinian governance is discussed in more detail at the end of this chapter, and in Chapter Two.

The MOH serves as a health care delivery system as well as a planning and regulatory body, creating the potential for conflicts of interest in the planning and policymaking process. It may therefore be beneficial to minimize the extent to which individuals or departments within the MOH have responsibility for both health care delivery and health system planning and policymaking. Options for distinguishing the two include creating a separate division within the MOH to be responsible for the government delivery system, creating an entirely separate agency with such responsibility, and privatizing health care delivery. Such options would need to be evaluated locally.

As an alternative method of broadening the policymaking process, national planning and coordination could be led by a new governmental body. The MOH would naturally play a significant role in this body, which would also include participants from the Ministries of Planning, Finance, and Education and Higher Education, and possibly other key players. To date, cooperation between the MOH and these other ministries regarding health policy has been limited, and effective cooperation may be more likely if all ministries jointly contribute to a new planning and coordination body.

Effective health planning and coordination also require appropriate oversight. The national planning and coordination body should ultimately be accountable to the prime minister; to the elected legislature, which defines the scope of the authority; and to the judicial system, which helps ensure that the body neither neglects nor exceeds its mandate. Many health systems have also developed formal processes for soliciting public input into planning and policymaking and an ombudsman process to help address consumer grievances.

Additional recommendations for strengthening the planning process are described below.

Health Planning Targets Should Reflect International Standards and Local Conditions. In many countries, and internationally, national targets for population health status, access to care, health care quality, and other indicators of health system performance play a vital role in guiding health system planning. Previous national health plans have included targets in some of these areas, framed largely in terms of local conditions. These targets should be revised and expanded on an ongoing basis, and they should reference—although not necessarily be identical to—international guidelines such as those developed by the WHO. Potential frames of reference for refining Palestinian targets include the WHO's Health for All in the 21st Century [online at http://www.who.int/archives/hfa/ (as of February 2004)] and the U.S. Healthy People 2010 targets [online at http://www.healthypeople.gov (as of May 2004)], in addition to data on health and health care in Palestine.

The Planning Process Should Be Inclusive. National health system planning should include meaningful participation by representatives from the NGO, private, and UNRWA sectors, in addition to government participants; from relevant professional associations (e.g., for physicians, nurses, pharmacists, etc.); from relevant academic institutions; from international donors; and especially from consumers and the community. In addition to ensuring consumer representation in national planning bodies, making meetings open to the public and including public hearings and a public comment period as part of policymaking are good strategies for promoting more comprehensive and effective consumer participation. Laws defining patients' rights can also strengthen the role of consumers in the planning and policymaking process; in Palestine, a draft patients' bill of rights was proposed by the Palestinian Council of Health, but no such policy has become law.

Formal participation by all stakeholders is likely to enhance the political and social legitimacy of the planning process and its outcomes, which in turn helps facilitate implementation of the plans.

Interview subjects expressed concern about the potential that the planning process might be "captured" by a small number of established stakeholders, or be dominated by specific personalities. Such issues are common to policymaking and regulatory bodies, and the planning process should be designed to reduce the chance of such outcomes.

Planning and Policymaking Should Be Integrated. The planning process should be comprehensive in scope and yield specific and measurable national targets for health status and health system development (in many ways, the previous national health plans have included such targets). These targets should guide policymaking for the health system.

In practice, the strategies for integrating planning and policymaking will differ for different stakeholders. In the government sector, the MOH and other ministries can be directed by statute or executive order to pursue such integration. It is important that health system budget allocations conform to and support national health development targets.

Government control over the policies of nongovernmental stakeholders is necessarily more limited; in particular, it is easier for the government to *prevent* donors or other organizations from implementing a particular project than to *compel* these organizations to implement a particular project. As a result, both regulatory oversight and positive incentives may be needed to increase integration with national plans. On the regulatory side, NGOs, private providers, or international donors can be required to seek approval for major capital investments, to ensure that infrastructure is developed in accordance with national plans; such an approval process should have established and transparent guidelines, and it should be binding. (This issue is further discussed under "Licensing and Accreditation of Health Care Facilities and Services" below.)

With respect to incentives, the MOH can use the coverage and payment rules of the government insurance programs to influence the scope and quality of service delivery in the private and NGO sectors; and it can increase commitment to the national health plans by including nongovernmental stakeholders in the planning process, as discussed above. Another possibility would be to establish an advisory panel of independent, international experts, which would advise the MOH and the national planning and coordination body and help provide support for policy decisions that are beneficial but may be unpopular.

Policy Implementation Should Be Strengthened. In the Palestinian health system, as in many other health systems, planning has frequently functioned better than policy implementation, and many of the aims of current and prior health plans have not been achieved. In our view, effective strategies for national health planning and coordination require that responsibility for implementing policy decisions be explicitly assigned to the appropriate stakeholders, with ongoing monitoring of implementation and appropriate incentives for successful performance. Subsequent recommendations in this chapter focus on the need to strengthen and maintain the skills of health system managers, evaluate new programs and policies, and collect comprehensive data about the health system.

Nearly all our interview participants expressed the view that the Palestinian government should *immediately* create a national planning and coordination authority with "teeth"—the power to ensure that health system policies and development proj-

ects conform to the national health plans. Although recognizing that such a body would influence and probably change how most health system stakeholders function, most interview participants considered its creation to be a necessary condition for addressing key problems in public health, health care access, health care quality, and financial viability of the health system. To the extent that opinions differed, they did so primarily with respect to the details of how such a planning body would be established and how it would function. However, even stakeholders in NGOs, the private sector, academic institutions, and international donor organizations agree that the planning body should be created under the auspices of the government, despite expressing concerns about the capabilities and the motivations of the MOH and the PA.

Effects of Restricted Domestic Mobility. Restricted mobility within Palestine would seriously inhibit essentially all aspects of health system planning, policy development, and policy implementation, as experience during the second intifada has shown. Since the start of the second intifada, the MOH has attempted few major development initiatives; those that have been attempted, such as a World Bank project on health information systems, have been delayed considerably; and coordination between MOH activities in the West Bank and Gaza has declined (from a level that was itself problematic). Continued restricted mobility would inhibit or prevent policymakers from meeting; inhibit or prevent oversight of health system functioning, including all types of data collection; and make implementation of new policies and programs more difficult and more costly.

Effects of Restricted International Access. Restricted international access would not necessarily inhibit the process of health system planning, policy development, and policy implementation, unless access by Palestinians to outside expertise and other resources is also restricted. However, it would affect the outcomes of the planning and policymaking process, by requiring that clinical and educational needs be met domestically. We discuss this further below.

Health Insurance and Health Care Finance

Background. During the period of Israeli administration, health insurance coverage was available primarily via the government health insurance plan; there was no private (commercial) health insurance, and informal insurance arrangements operated by NGOs were very limited. (Of course, the UNRWA health system functions as a health service benefit program for registered refugees.) Participation in the government plan was restricted to the groups who were required to enroll—i.e., government workers and Palestinians working in Israel. Under Israeli administration, the insurance program was priced to be largely self-funding, so that the annual premium corresponded to the average annual cost of covered services used by members. The Israeli administration had relatively strong control over the services offered in the government sector.

Nearly all Palestinians with health insurance obtain it through the MOH's insurance program. After 1994, some private health insurance was introduced, but these